

RECOMMENDED FOLLOW UP

Adult in Health Care System		
1	Adult at risk, every 3 years (age >45)	Screen for diabetes (fasting plasma glucose [FPG] test)
2	Adult with fasting plasma glucose $\geq 110 < 126$	Lifestyle modification (exercise and diet to achieve weight loss)
Adult with Diabetes		
3	Initial visit following diagnosis	Patient education: comprehensive diabetes education and skills Influenza vaccination (in season)
4	Each routine primary care visit	Visual foot inspection if high risk for foot problems Tobacco assessment and counseling or referral for users Blood pressure measurements Review results of self-monitoring of blood glucose if monitored
5	Quarterly to annually	HbA _{1c} measurement and risk assessment
6	Annually	Dilated eye exam (every other year if no history of retinopathy or eye risk factors) Microalbuminuria / proteinuria screening and monitoring Lipid profile Visual inspection, foot risk assessment & education Influenza vaccination (in season)
7	When HbA _{1c} is not on target	Glycemic control management (diet, exercise and medication) Self-management, nutrition assessment and goal development
8	When change in vision, or eye risk factors	Referral to eye care provider for evaluation and treatment of retinopathy
9	Age 40 OR onset of cardiovascular disease risk factors	Consider aspirin prophylaxis
10	Confirmed microalbuminuria or SBP ≥ 140 or DBP ≥ 80	ACE inhibitor therapy if not contraindicated and if tolerated
11	Per national cholesterol guidelines (LDL-C ≥ 130)	Statin therapy

VA/DoD Clinical Practice Guideline for the
Management of Diabetes Mellitus in Primary Care
Pocket Guide

RECOMMENDED FOLLOW UP
UPDATE 2003

<ul style="list-style-type: none">Consider aspirin therapy for patients with diabetes age > 40 OR evidence of cardiovascular disease risk factorsIf the patient is a candidate for an influenza vaccine, administer it in seasonAdminister pneumonia vaccine, if indicatedIf the patient is using tobacco, refer to the VA/DoD Clinical Practice Guideline for the Management of Tobacco Use Cessation	
IF	GO TO
If the individualized HbA _{1c} is not at target	Module G – Glycemic Control
If SBP ≥ 140 or DBP is ≥ 80 mmHg	VA/DoD Guideline for the Management of Hypertension
If a lipids evaluation was not done within one year or the patient has elevated cholesterol or lipids	VA/DoD Guideline for the Management of Dyslipidemia
If a renal evaluation was not done within one year or the patient has micro-/macroalbuminuria or elevated creatinine	Module R – Kidney Function
If an eye evaluation was not done within two years, the patient has symptoms, or a previous exam showed a high risk for visual loss or retinopathy	Module E – Eye Care
If a foot-risk assessment was not done within one year or the patient has risk factors or an active lesion	Module F – Foot Care
If the patient needs additional nutritional or lifestyle education	Module M – Self-Management and Education

VA access to full guideline: <http://www.oqp.med.va.gov/cpg/cpg.htm>

DoD access to full guideline: <http://www.gmo.amedd.army.mil>

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DIAGNOSIS OF DIABETES MELLITUS

Status	Fasting Plasma Glucose (FPG) (Preferred) (a), (b)	Casual Plasma Glucose
Diabetes Mellitus	FPG ≥ 126 mg/dL (7.0 mmol/L)	Casual plasma glucose ≥ 200 mg/dL (11.1 mmol/L) plus symptoms of diabetes (c)
Impaired Glucose Tolerance	Impaired fasting glucose (IFG) FPG ≥110, <126 mg/dL	—
Normal	FPG <110 mg/dL	—

- (a) Fasting is defined as no caloric intake for at least 8 hours.
- (b) FPG is the preferred test for diagnosis, but either of the two listed is acceptable. In the absence of unequivocal hyperglycemia with acute metabolic decompensation, one of these two tests should be used on a different day to confirm the diagnosis.
- (c) “Casual” means any time of day without regard to time since the last meal; classic symptoms include polyuria, polydipsia, and unexplained weight loss.

Foot Care

- Every patient with diabetes must have an annual documented foot risk assessment
- Every high-risk patient should have a visual inspection of his/her feet at each routine primary care visit

Eye Care

- Persons who have had no retinopathy on all previous examinations should be screened for retinopathy at least every other year
- Persons who have ocular risk factors, are on insulin, or have had retinopathy detected on a previous examination should have a yearly fundus examination

Definition of Chronic Kidney Disease Criteria

1. Kidney damage for ≥ 3 months, as defined by structural or functional abnormalities of the kidney, with or without decreased glomerular filtration rate (GFR), manifest by *either*: □
- Pathological abnormalities; OR
 - Markers of kidney damage, including abnormalities in the composition of the blood or urine, or abnormalities in imaging tests
2. GFR <60 mL/min/1.73m² for ≥ 3 months, with or without kidney damage

CHRONIC KIDNEY DISEASE (CKD):
A CLINICAL ACTION PLAN

Stage	Description	GFR (mL/min/1.73m ²)	Action
	At increased risk	>90 (with CKD risk factors)	• Screen and CKD risk reduction
1	Kidney damage with normal or ↑ GFR	≥90	• Diagnose and treat • Treat comorbid conditions • Slow progression • CVD risk reduction
2	Kidney damage with mild ↓ GFR	60 – 89	• Estimate progression
3	Moderate GFR	30 – 59	• Evaluate and treat complications
4	Severe ↓ GFR	15 – 29	• Prepare for kidney replacement therapy
5	Kidney failure	<15 (or dialysis)	• Replacement (if uremia present)

Dyslipidemia Treatment in Patients with Diabetes

	Baseline LDL-C [mg/dL]	
	≥100	≥130
Diabetes (with or without known CHD)	Diet & Exercise Consider drug therapy	Diet & Exercise Initiate drug therapy
LDL-C ≤130 mg/dL and HDL-C < 40 mg/dL	Consider gemfibrozil	

Hypertriglyceridemia in Patients with Diabetes

Diabetes with triglycerides (TG) 400-1000 mg/dL	Consider gemfibrozil if HDL-C < 40 mg/dL For high TG, use direct LDL-C measurement or non-HDL-C as lipid disorder to guide therapy
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DETERMINATION OF TARGET HbA_{1c} LEVEL

Major Comorbidity ^(d) or Physiologic Age	Microvascular Complications		
	Absent or Mild ^(e)	Moderate ^(e)	Advanced ^(e)
Absent >15 years life expectancy	7% (<1% above upper normal range)	<8% (<2% above upper normal range)	<9% (<3% above upper normal range)
Present^(e) 5 – 15 years life expectancy	<8 % (<2% above upper normal range)	<8% (<2% above upper normal range)	<9% (<3% above upper normal range)
Marked^(e) <5 years life expectancy	<9% (<3% above upper normal range)	<9% (<3% above upper normal range)	<9% (<3% above upper normal range)

- (a) Mild microvascular disease is defined by early background retinopathy, and/or microalbuminuria, and/or mild neuropathy.
- (b) Moderate microvascular disease is defined by pre-proliferative (without severe hemorrhage, intra-retinal microvascular anomalies [IRMA], or venous bleeding) retinopathy or persistent, fixed proteinuria (macroalbuminuria) and/or demonstrable peripheral neuropathy (sensory loss).
- (c) Advanced microvascular disease is defined by severe non-proliferative (with severe hemorrhage, IRMA, or venous bleeding) or proliferative retinopathy and/or renal insufficiency (serum creatinine level > 2.0 mg/dL) and/or insensate extremities or autonomic neuropathy (e.g., gastroparesis, impaired sweating, or orthostatic hypotension).
- (d) Major comorbidity includes, but is not limited to, any or several of the following conditions: cardiovascular disease, chronic obstructive pulmonary disease, chronic liver disease, stroke, and malignancy.
- (e) Moderate degree of major comorbid condition.
- (f) Severe degree or end-stage major comorbid condition.